The elements of cancer and palliative care reform in Victoria

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## Overview

- Rural and regional Victoria
- Objectives of reforms
- Principles underpinning reforms
- Structures to drive change
- Focus of work being undertaken
- Measuring change
As this conference is focussed on rural health, this is an overview of cancer in the Victorian Rural Regions

Total Population of Victoria in 2006 – close to 5.1 million
Total population living in rural and regional Victoria in 2006 – close to 1.4 million
-representing approx 27.5% of total population

Number of people diagnosed with cancer in Victoria in 2006 – close to 24,450
Number of people diagnosed with cancer in rural and regional Victoria in 2006 – 7,400 (30% of total).
AIHW predicts a 40% increase in new cases by 2016.

Cancer accounts for 29% deaths
Approx 80% palliative care services provided to people with cancer
20% of all WIES in major public hospitals is spent on patients with a diagnosis of cancer
Life expectancy for many cancers is increasing and people are living with the disease longer.
Objectives of reforms

- Manage the burden of cancer
- Create better patient experiences
- Improve survival rates
- Improve access to clinical trials
- Translate research into practice
- Improve patient choices

The **objectives** of the reforms are to:
- Manage the burden of cancer on the health system and on patients and communities
- Create better patient experiences of cancer care
- Improve survival rates through consistent implementation of evidence-based care
- Improve access to clinical trials and most up to date treatments
- Speed up translation of research into practice and use of emerging technologies
- Improve patient choices throughout pathway of care, including end of life care
Principles underpinning reforms

• Provision of quality care
• Integrated, coordinated multidisciplinary care
• Collaboration and partnerships
• Patient focussed
• Continuity of care
• Appropriate and timely care
• Access

In alignment with the Victorian government’s vision for the development of the health system in rural Victoria, outlined in *Rural Directions for a better state of health*, the reform agenda in cancer and palliative care is underpinned by the following principles:

• Provision of best practice, quality cancer and palliative care
• Integrated, coordinated multidisciplinary care available to all Victorian cancer and palliative care patients
• Collaborative planning and working relationships between health services, health sectors, health professionals and consumers
• Continuity of care experienced by patients
• Provision of appropriate and timely supportive care for patients, carers and families
• Access to services as close to home as possible
Cancer and palliative care reforms

• New approach to service planning and improvement

• Reform existing systems, structures and processes

• Collaborative endeavour

To achieve the objectives of the cancer and palliative care reforms, based on the principles I have just mentioned,

• The cancer and palliative care reforms in Victoria represent a new approach to service planning and improvement. It recognises that cancer and palliative care needs to be integrated and coordinated around the needs of people, rather than service types, professional boundaries, organisational structures and funding.

• The intention is to reform existing systems, structures and processes to increase the capacity of the system to respond to increases in demand and to meet patient preferences for convenient, accessible and locally available services.

• The cancer and palliative care reforms are based on collaborative endeavours between services and clinicians to improve patient outcomes and their experience.

• To enable this to happen, structures needed to be established to drive the improvements required and to bring together all stakeholders.
At a statewide level.

- The MTFC was established to advise on the implementation of the cancer reforms.

- The Victorian Integrated Cancer Services Committee is shortly to be established to explore the strategic areas of quality, data and funding that will bring ICS to the centre of health service planning and delivery of care.

- The Victorian Cancer Agency (VCA) is responsible for providing strategic advice to Government and management of initiatives that align and link research to improve the translation of research findings to the clinical setting.

- The department has a unit that is responsible for overseeing the implementation of the reforms required and development of policy to guide implementation.
A critical element of the cancer reforms has been to ensure that there are structures to support a cultural shift from a competitive model where health services work in isolation to a collaborative model.

- **Integrated Cancer Services** (ICS) which are clusters of hospitals and associated health services that deliver services for people with all types of cancers within a geographic area. Three ICS have been established in metropolitan Melbourne and five ICS have been established in regional Victoria.

- The **aim of the ICS** is to strengthen the governance, leadership, collaboration and accountability for cancer service planning and service delivery, and to improve the quality of cancer care.

- The ICS have establishing **local collaborating tumour groups** to consider tumour specific issues across their ICS. The groups provide opportunities for clinical networking, multidisciplinary team development and service development with a tumour specific focus. Membership of these groups includes health professionals involved in the care of cancer patients as well as consumers.

- **Palliative Care Consortia** comprise all funded palliative care services (including inpatient and community services) in each DHS region to address priority areas of work in each region.
Focus of Integrated Cancer Services (ICS)

- Priority outcome areas
  - multidisciplinary care
  - psychosocial and supportive care
  - coordinated care
  - Reducing variation
- Patient Management Frameworks

The complexity of cancer care and the cancer care system requires that we focus our efforts in order to see tangible outcomes. There are two ways in which we have focussed the effort of cancer services.

The first was in defining priority outcome areas. The emphasis on effective and appropriate care, within a complex and rapidly changing clinical environment, is universal in cancer care, with both stakeholders and the literature reinforcing the need to provide every patient with care that is evidence based and consistent with best practice care where possible.

The focus on these priority outcome areas directs the Integrated Cancer Services to support initiatives that are likely to make the most difference to patient outcomes. The Regional ICS currently have 65 initiatives being planned or implemented to address the priority areas.

Next Slide
The second was in clearly **articulating optimal care** through the Patient Management Frameworks.

The **Patient Management Frameworks** are intended to improve patient outcomes by facilitating consistent care based on evidence and best practice across the state.

By defining optimal care, we have a common purpose to which we are working with a common language.
• This is what the PMFs look like.
Fourteen frameworks have been developed across ten tumour streams. They are a tool to care to guide service mapping, local benchmarking, service planning and quality improvement.

• Copies can be obtained from the website
How will we know reforms are working?

• Measurement critical - quantitative and qualitative
• Measures need to be valid, reliable, accurate, collectable, meaningful, relevant and important
• Clinical performance measurement
• Data required– clinical, research, service improvement

Measuring, monitoring and improving cancer services is a challenge given the complexity of cancer care and the range of organisations in which it is planned and delivered.

• **Measurement of the current state of play and of change is a critical element of the reforms.** Research shows that the internal feedback of quality indicators, combined with other quality improvement interventions raises standards of care, and professional peer comparisons within multi-hospital collaborations can drive service improvement.

• A variety of **strategically chosen quantitative and qualitative measures** are needed to fully understand cancer care services.

• To be useful in informing care and service improvement, **measures need to be valid, reliable, accurate, collectable, meaningful, relevant and important to those who will use them.**

• **Clinical performance measurement** provides the opportunity to monitor, evaluate and review the practices of an organisation and/or clinician ensuring continuous improvement in the safety and quality of care.

• **To undertake this data** is needed at all levels of care: clinical, research and service improvement.
In moving forward this year, the Clinical Excellence in Cancer Care: a model for safety and quality in Victorian Cancer Services has been developed and will provide a blueprint for ICS to drive an integrated approach to safety and quality in cancer care.

The model is currently being introduced through the ICS and will enable measurement and monitoring of the cancer reforms.

• Incentives for reporting and participation lie with evidence that identified opportunities for improvement are acted on through provision of administrative and clinical resources and support – ICS are the infrastructure to support this.
In closing, this is a diagrammatic summary of how everything links together to achieve the objectives of the Victorian cancer and palliative care reforms.

These reforms aim to:

Deliver integrated, high quality, evidence based treatment, information and support for people with cancer.

and

Improve access, equity, quality and coordination of services.

We have to ensure that our health service system and workforce is supported and has the capacity, skills and knowledge to enable this to be achieved.